

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022538

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 347

Primary Registration District No. 500

Registrar's No. 1623

FILED MAY 27 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Ellisville</u>		Length of stay in 1b <u>11/15/62</u>	c. CITY OR TOWN <u>Manchester</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Doctors Med. Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>P.O. Box 364</u>

3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>DeClue</u> Middle Last			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-1904</u>	9. AGE (last birthday) <u>59</u>	10. IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jet Transmissions</u>		11. BIRTHPLACE (City and state or country) <u>Sullivan, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Paul W. DeClue</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Barrett</u>	
14. NAME OF HUSBAND OR WIFE <u>Jennie S. Nee Stevens</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>12</u>	
17. INFORMANT <u>Jennie S. DeClue</u>		18. ADDRESS <u>Box 364, Manchester, Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Thrombosis - with Myocardial Infarction</u>	
	DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9:40</u> a.m. <u>PM</u>	Month <u>2</u> Day <u>18</u> Year <u>63</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Ellisville Mo</u>	20g. COUNTY <u>Cuba</u>
21. I attended the deceased from <u>2-18-63</u> to <u>5-19-63</u> and last saw her/him alive on <u>5-19-63</u> Death occurred at <u>9:40 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>L.T. Bornhill D.O.</u>	
22b. ADDRESS <u>Ellisville Mo</u>		22c. DATE SIGNED <u>5-19-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>May 23 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kinder Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cuba Mo.</u>
24. FUNERAL DIRECTOR <u>Paul P. Thompson</u>	25. ADDRESS <u>Cuba, Mo.</u>	25. DATE REC'D. BY LOCAL REG. <u>5-20-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

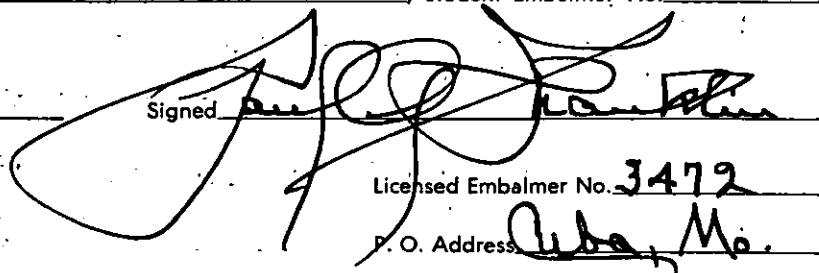
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed



Licensed Embalmer No. 3472

P. O. Address Cuba, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.